What Does the Empirical Evidence Say? Simple Things that Save Lives

M. David Rudd, Ph.D.

Texas Tech University

David.rudd@ttu.edu

Understanding Re-attempt Rates

- Rudd, Bryan et al. (2009)
  - Reviewed all available clinical trials targeting suicidality with a comparison group (not all randomized)
  - N=53, with 12-month follow-up
  - Classified samples as High, Moderate, and Low risk (IAW inclusion/exclusion criteria)
    - High: suicide attempts
    - Moderate: self-harm, undetermined suicide-related behavior
    - Low: ideation

- High: Suicide Attempt Precipitating Treatment
  - Range: E (24%-64%), C (30%-96%)
  - Mean: E (40%), C (56%)
  - If there's a reattempt, the average is slightly over 2 in the first year
- Moderate:
  - Mean: E (17%), C (26%)

What Does it Mean?

1. Suicide risk is inherent to treatment
2. The “expected” re-attempt rate is around 50%
3. These are high-risk patients

What Do Effective Treatments Have in Common? Why do They Work?

- We need to talk in simple and understandable terms about suicide
  - Clearly articulated treatment model and suicidality as targets
  - Patients can understand and invest
  - Better compliance, motivation?
  - Facilitates hope? Sense of control?
- People need to be appropriately trained
  - Manuals available to guide training and treatment targeting suicidality directly, i.e. skill deficits
  - Better fidelity?
- When People drop out of treatment, action needs to be taken
  - Treatment compliance closely monitored and addressed
  - Motivation, ambivalence, and intent to die

- People that are suicidal have poor skills
  - Skills deficiencies targeted, not just symptoms
- People need to take ownership of their treatment
  - Addressed self-reliance, self-awareness, individual control
  - Commitment to treatment
- People need to know what to do during a crisis
  - Crisis management/access to emergency services
  - Limited access to method

Concrete Management of Suicide Risk

- Informed Consent
  - Lays the ground rules, expectations (risks/benefits)
- LIMIT ACCESS TO METHOD
- SYMPTOM MANAGEMENT
  - ALWAYS CONSIDER MEDICATIONS!
- Commitment to Treatment Agreements
  - The problem of no-suicide contracts
- Crisis Response Plans
  - Using a Hope Box
- ER Discharge Cards
- Coping Cards: Reasons for Living (Hope Box)
- Non-compliance Protocols/plans

Facilitating Hope (*and feeling in control*) During the First Contact

- Provide an understandable model
  - Explain why the suicide attempt(s) happened
- Contextualize/Normalize the problem
  - Sensitized to the sights, sounds, smells of war (problem is that many generalize to day to day living, particularly given the urban nature of much of this conflict)
- Label and reinforce the presence of ambivalence
  - *Reasons for living, reasons for dying*
- Don't struggle for control by arguing about suicide as an option
  - *Data mentioned previously, it's a risk with psychiatric illness*
- Identify a common goal (reduces adversarial tension)
  - *Reduce suffering and emotional pain*
- Provide a crisis management or safety plan (and practice it)

Journaling Plays a Critical Role (development of insight)

- Keeping a treatment journal
  - Start at the first session
  - Provides structure, safe outlet, historical memory, ability to track change
  - *Journals have been demonstrated to be a useful intervention in treatment, particularly to improve self-awareness, understanding of change over time and as tool for relapse prevention. Your journal will provide an easy and ready reference for what you've done in treatment, identifying what's worked and what has not, with an emphasis on becoming more efficient and effective in problem solving, regardless of the situation. Here are the ground rules for keeping your journal:*

- Journal for 15-30 minutes per day. Try to do it at the same time each day, it's important to make this part of your daily routine. I want you to write only as much as I can reasonably read and cover with you in treatment. This is particularly important early in the treatment process. I'll make copies of your journal to keep and review.
- For the first month I'd like for you to journal about things that are *important* to you. That is, what's on your mind? What's upsetting you? How are you feeling about yourself? How are you feeling about other people? When you write about these things, please try to identify specifically what the problem is so that we can target it in treatment. We'll talk about a specific approach to problem solving.

- If you write about suicidal thoughts, feelings and plans, we'll target these directly in treatment. If you right about reasons for dying, I'm going to ask you to always include your reasons for living. If you have trouble identifying them, I'll help you. Use your coping card.
- Within the first couple of weeks, I'm going to ask you to identify the problem specifically when you write, generate and write about alternative responses, practice implementing the alternatives (we'll role play these to help you), evaluate whether or not it's working, and if it's not, identify a new one and try again.
- Finally, I'm going to ask you to always close your writing each day by adding a single sentence about what your hopeful about in treatment and life.

Philosophy of Living Statement

- *After careful review, much time and effort, I've decided to make the following changes in my rules for living:*
  - *Accept the fact that I'm not perfect and never will be*
  - *Do the best job I can and feel good about it.*
  - *Work on accepting the things I can't change*

The Problem and Controversy of No-Suicide Contracts

- Have limited value and meaning
- No empirical support
- Pose a potential liability
- More a reflection of clinician anxiety and lack of control
- Not actually a therapeutic intervention
- Hidden messages
  - blame, control, *open* communication

An Empirical Foundation? A Review of the Literature

- A total of 21 articles identified
  - Frequency of use
  - Opinions (favorable, non-favorable)
    - Patients
    - Clinicians
  - Perceived utility
  - Potential problems, liability concerns

- Three useful empirical studies
  - Drew (2001)
    - Patients with no-suicide contracts more likely to engage in self-harm (retrospective chart review)
  - Kroll (2000)
    - 41% of clinicians using no-suicide contracts had patients die by suicide or make serious attempts while under an agreement
  - Kelly & Knudson (2000)
    - *No empirical evidence supports the effectiveness of no-harm contracts in preventing suicide.*

General Conclusions from the Literature

- Agreements routinely used
- No empirical evidence of effectiveness
  - Reducing targeted behaviors?
    - Direct and indirect markers of suicidality
  - Increasing use of emergency services?
  - Facilitating improved therapeutic relationship or general treatment outcomes?
- Not theoretically driven or related

Some Troubling Trends and Questions?

- Evidence of lack of formal training and theoretical models for use with suicidal patients
- Evidence of increasing use with those at higher risk
  - Despite a lack of data on effectiveness
- Evidence of high-rates of attempts/suicides while in use
  - 41% made an attempt, completed suicide

Elements of a Good Agreement?

- Defined as a commitment to
  - Living
  - Treatment and care
- Incorporates a crisis management or response plan
- Specifically identifies responsibilities
  - Patient
  - Clinician

- Includes behaviors for which the patient has demonstrated competence
- Is modified routinely
  - At request of patient or clinician
  - When indicated by clinical markers
- Is individualized

Commitment to Treatment Statement

- *I agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment including:*
- *attending sessions (or letting you know when I can't make it)*
- *voicing my opinions, thoughts, and feeling honestly and openly, whether negative or positive*

CTS (continued)

- *being actively involved **during** sessions*
- *completing homework assignments*
- *experimenting with new behaviors and new ways of doing things*
- *taking medication as prescribed*
- *implementing my crisis response plan.*

CTS (continued)

- *I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. It it's not working, I'll discuss it with my therapist. In short, I agree to make a* ***commitment to living for……***
- ***I also understand that this means we're working toward the common goals of***
  - *Feeling better*
  - *Improving my abilities to handle different situations and problems*
  - *Finding direction and meaning in my life*

Effective Management of Crises Means Facilitating Hope in Treatment

- Define *crisis*
- Make it accessible! Put it on a card!
- ALWAYS ELIMINATE ACCESS TO METHOD
- Identify warning signs! (for parents/partners as well)
- Specific goal is to reduce escalation of suicidal crisis and reduce manifest intent (increase hope)
- Moves from self-management to external intervention—improve self-efficacy.
- If not successful, access emergency care and assistance in manner that facilitates skill development (always understand the cost and consequence)

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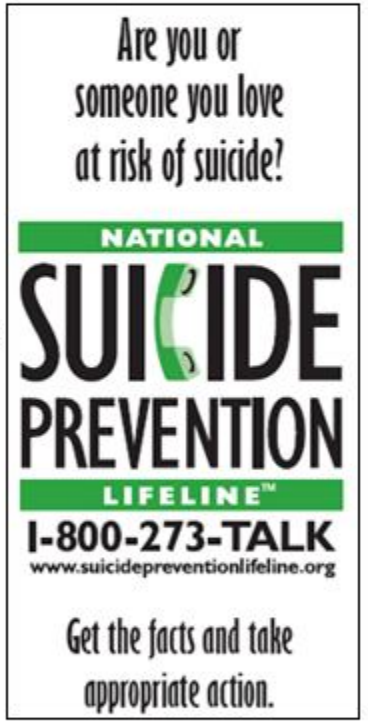
Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at
1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities - seemingly without thinking
- Feeling trapped-like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life



Practice, Practice, Practice *and translate to beliefs*

- *When thinking about suicide, I agree to do the following:*
- *When I find myself making plans to suicide, I agree to do the following:*
- *1. Use my hope box. I can feel more hopeful.*
- *2. Review my treatment journal. I've managed these feelings before.*
- *4. Do things that help me feel better for about 30 minutes, including taking a bath, listening to music, and going for a walk*
  - *I can do things to feel better.*
- *6. If the thoughts continue get specific, and I find myself preparing to do something, I call the emergency number XXX-XXXX*
- *7. If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room*

Creating a Hope Box

- The notion of reciprocal inhibition
- Include items that generate productive, hopeful thoughts and feelings
- Always review items individually
- Practice use of Hope Box
  - Review each item
  - Ask patient to describe item, “tell a little about it”
  - What are they thinking?
  - What are they feeling?
  - More hopeful?

ER Discharge Card

- *You (or your child) have been referred to the Emergency Room in order to be evaluated for hospital admission. This means that your level of risk for suicide is currently considered to be elevated and we are concerned about your safety. <u>If you are discharged from the Emergency Room and NOT admitted to the hospital please follow these steps:</u>*

- Prior to leaving the ER, call the emergency call number (XXX-XXXX) and tell the individual on call what has happened. They will have some questions for you and may well ask you to stay in the ER until they have had a chance to talk with the ER physician about your situation. Please wait until the staff member on call gives you permission to leave the ER. The staff member on call will confirm that you do NOT have access to any method for suicide if you are leaving the ER. They will also confirm you do NOT have access to substances such as alcohol or other drugs.
- The staff member on call will provide you with a specific day and time for your emergent follow-up appointment in the clinic. This will likely be the next morning. Please do NOT leave the ER without a specific day and time to follow-up in the clinic.

- Use your crisis response plan until you follow-up in the clinic. This is what you normally do between appointments and you should have practiced this with your therapist.
- If you do not feel safe leaving the ER, please tell the on call staff member.
- For parents, it is requested that you closely monitor and supervise your child until the follow-up appointment. This means that your child should not be left alone until the follow-up appointment and should not be allowed to leave you or another identified adult's presence. They should be monitored at all times until the follow-up appointment. The on-call staff member will review with you the importance of removing access to all methods for suicide (and related safety procedures regarding constant observation and access to substances). If you do not believe you can accomplish careful monitoring you need to let the on call staff member know.

Reasons for Living Coping Card

- Provides a ready reminder of reasons for living
  - Facilitates cognitive fluency, problem solving
- Can be integrated into Hope Box
- Make it accessible and specific
  - If reasons are not available, strategize offer reasons
    - Building relationships important

Non-Compliance Protocols/Plans

- Follow-up no-shows, treatment withdrawals
  - Phone calls, letters
- Identify reasons for drop-out, non-compliance
  - Can be addressed during initial intake, informed consent
- Rewrite commitment to treatment agreement to address compliance problems
- Make sure to address non-compliance with crisis response plan

Symptom Hierarchies

- Early in process mixed symptomatology
- Severity and related disruption fuels hopelessness and feelings of being out of control
  - *What symptoms cause you the most trouble?*
- Rank symptoms from low to high (1-10)
  - *Severity, distress, upset, dysfunction*
- Target one symptom at a time
  - Although they're interconnected

Example: JoAnn

- 10: Sleep Disturbance
- 9: Binge/purge episodes
- 8: Anxiety/panic attacks
- 7: Cutting
- 6: Depression